New York State Perinatal Quality Collaborative (NYSPQC): Improving Perinatal Health through Partnerships and Collaboration

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New York State nyspQc Perinatal Quality Collaborative

NYSPQC Mission

Provide the best and safest care for women and infants in New York by preventing and minimizing harm through the translation of evidence-based practice guidelines to clinical practice.

New York State nyspQc Perinatal Quality Collaborative

Leadership Quality & Action

NYSPQC Focus Areas

- Obstetrical Improvement Project
  - Reducing scheduled deliveries
- Neonatal Projects
  - Enteral Feeding Improvement Project
  - Central Line Associated Blood Stream Infection (CLABSI) Reduction Project
- Maternal Mortality Initiative

Obstetrical Improvement Project

Began September 2010

Goal:

Reduce scheduled deliveries without a medical indication between 36 0/7 and 38 6/7 weeks gestation.

Neonatal Enteral Feeding Improvement Project

Began February 2011

Goal:

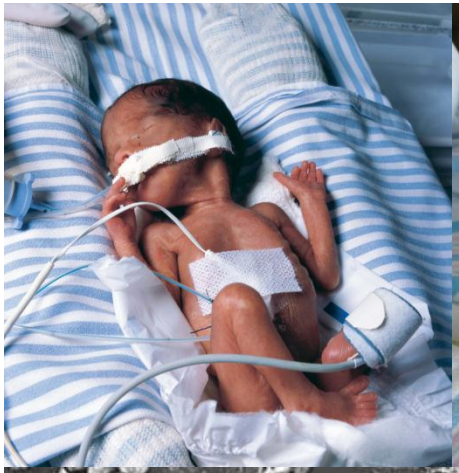
Reduce statewide the percentage of newborns ≤ 30 6/7 weeks gestational age that are discharged from the NICU below the 10th percentile of the Fenton Growth Scale.

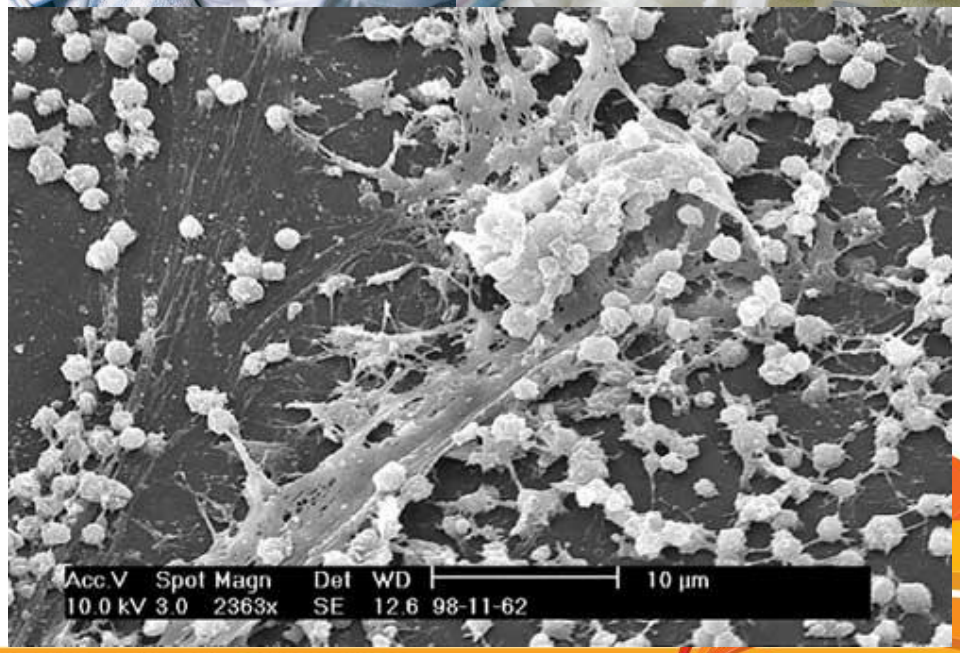
NICU CLABSI Reduction Project

Began in 2007

Goal:

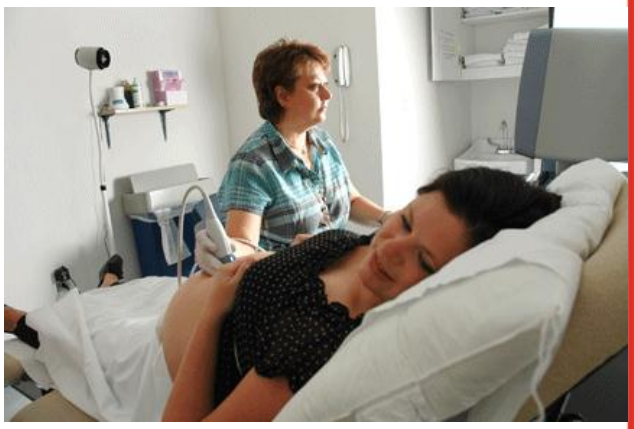
Decrease central line associated bloodstream infection (CLABSI) rates in NICUs.





Rationale for Interventions

- Reflect hospital-based care
- Address inter-related newborn health care risks related to prematurity
- Address major national health concerns
  - ACOG
  - The Joint Commission



In the Beginning . . .

- No full-time dedicated staff
- Very limited funding
  - State dollars
  - In-kind
- With few resources and minimal incentives, the NYSPQC Project Team was unsure of how many facilities would participate

Initial Partnerships

- National Initiative for Children's Healthcare Quality (NICHQ)
  - Clinical support
  - Quality improvement support
- Regional Perinatal Centers
  - First facilities to participate in all projects

NYSPQC Resources

- The NYS DOH organized the projects, and were able to provide Collaborative participants with resources such as:
  - Data systems
  - Technical support
  - Leadership
  - Clinical experts
  - Quality improvement support

Leadership at All Levels

- Leadership at NYS DOH
  - Executive leadership
  - NYSPQC Project Team

- Clinical leadership
  - NYSPQC Advisory Work Group
  - Obstetrics Expert Work Group
  - Neonatal Expert Work Group

Engagement and Success

- Almost all Regional Perinatal Centers signed on for all three projects
- Provided constant data feedback
- Leaders emerged
- Small successes = big victories

Lessons Learned

- Potential participants may be skeptical
  - Feel they don't need improvement
  - Lack time and/or resources

- Participants who were skeptical at first tend to become very engaged over time

Lessons Learned

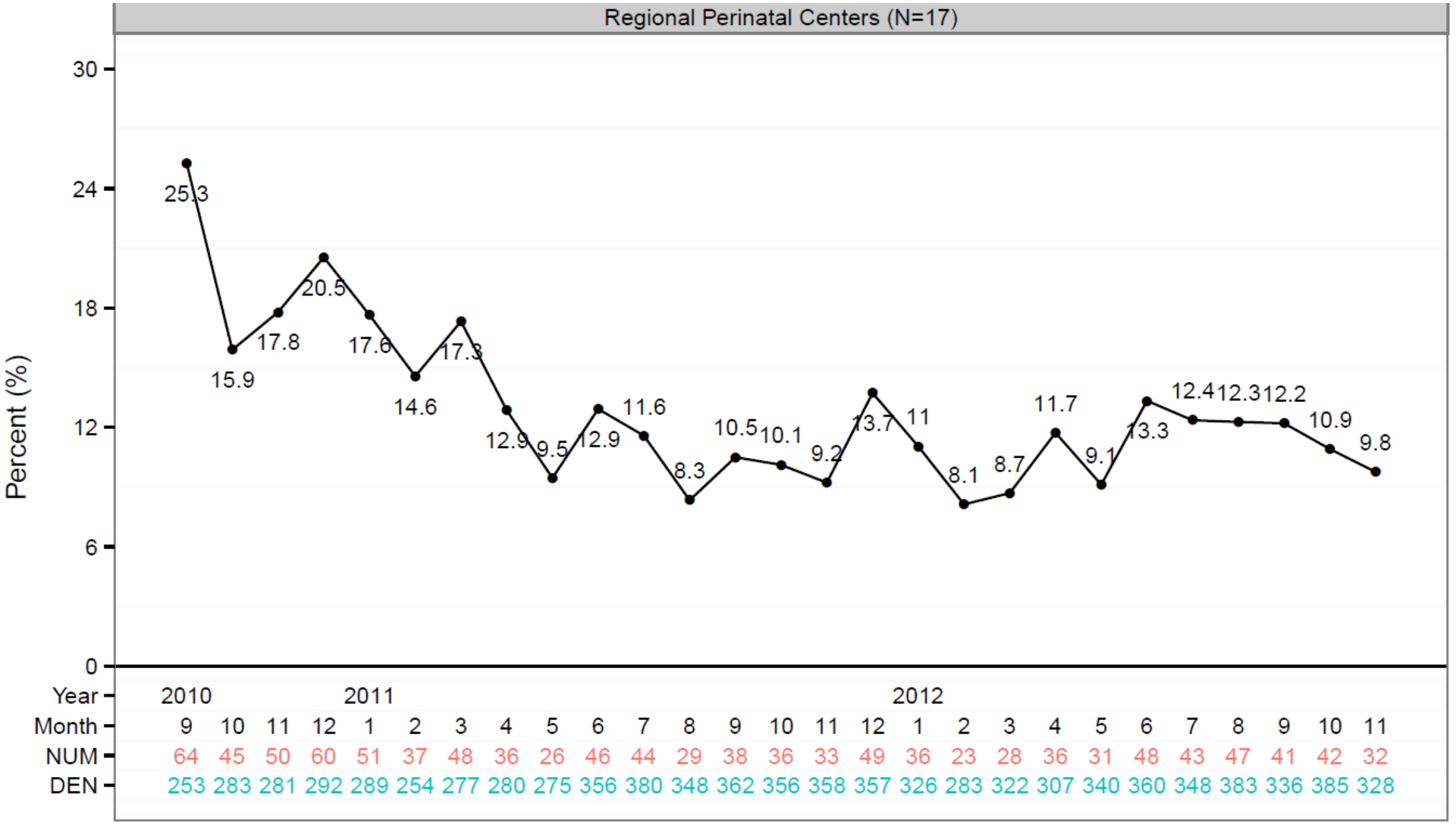
- Engagement
  - Highlight "what's in it for them"
  - Data will often speak for itself
  - Present rates compared to peers
  - Want to participate if other facilities are participating
  - There is **always** room for improvement

Phase 1
Project Results

Obstetrical Improvement Project
RPC Results

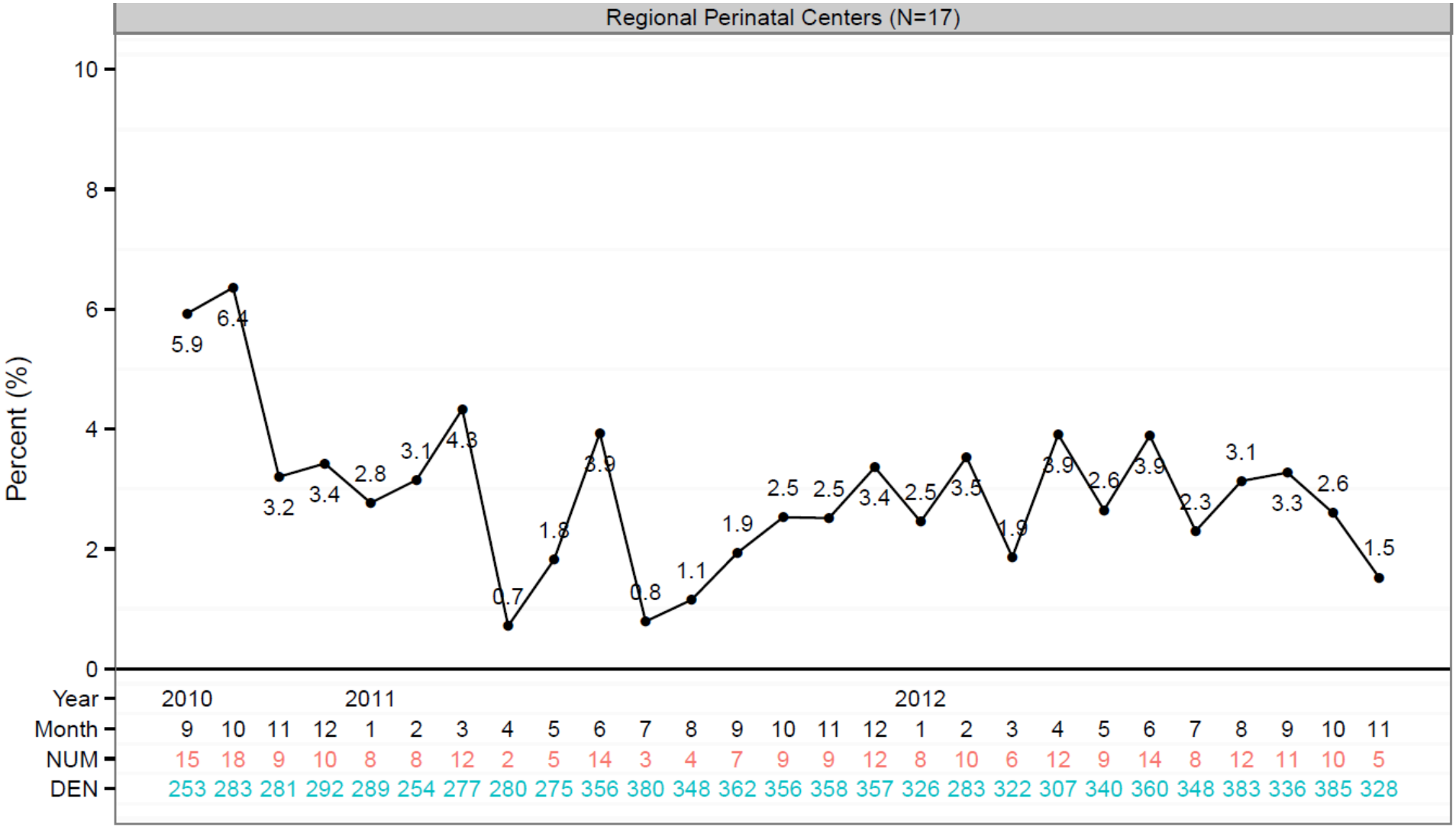
percent All Scheduled Deliveries Without Indication

Measure 3. Percent of **all scheduled deliveries** at 36 0/7 to 38 6/7 weeks without medical or obstetrical indication documented of all scheduled deliveries.



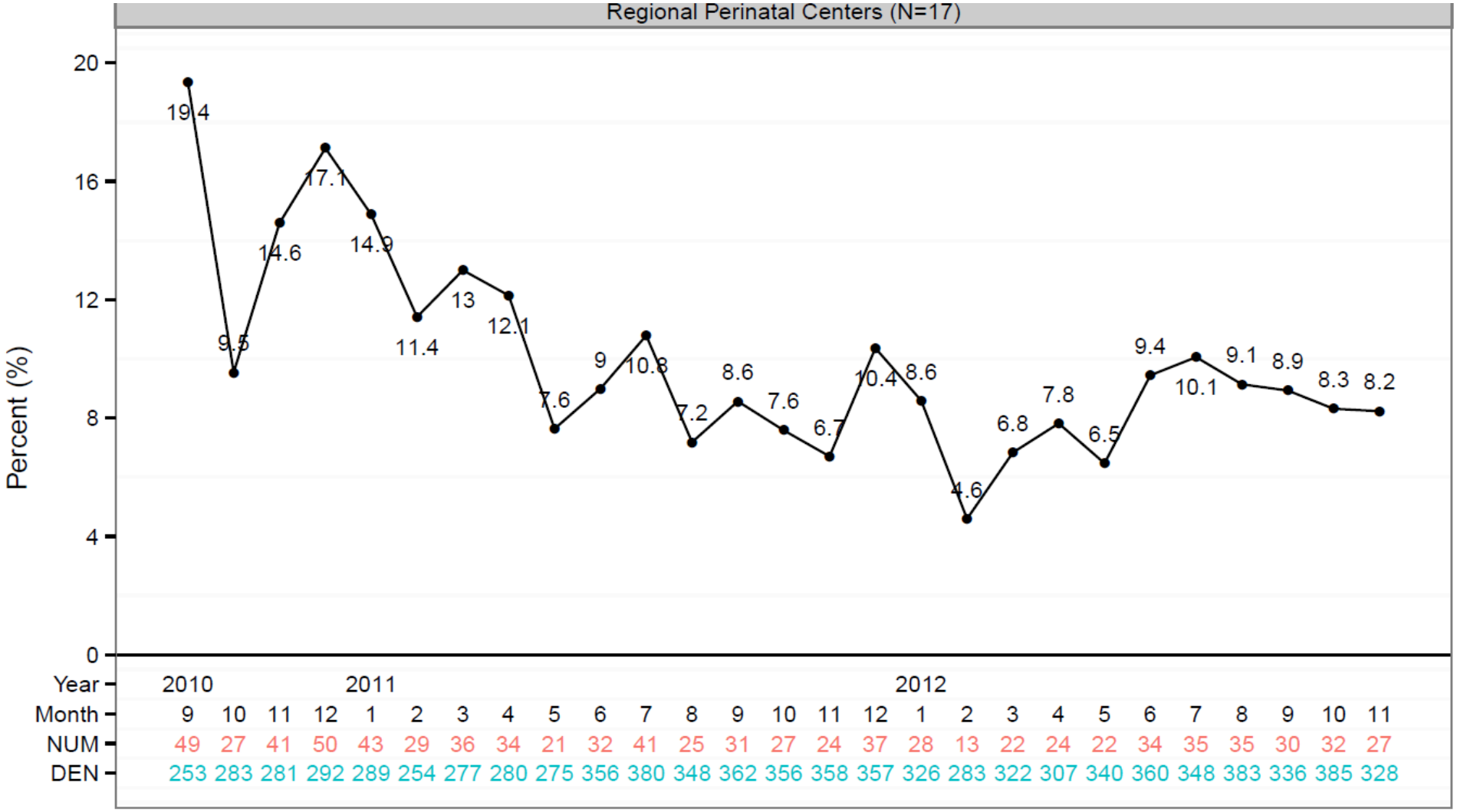
Scheduled Inductions with No Indication (Of All Scheduled Deliveries)

Measure 1a. Percent of scheduled inductions at 36 0/7 to 38 6/7 weeks without medical or obstetrical indication documented of all **scheduled deliveries.**



percent Scheduled C-sections with No Indication (Of All Scheduled Deliveries)

Measure 2a. Percent of **scheduled C-sections** at 36 0/7 to 38 6/7 weeks without medical or obstetrical indication documented of all **scheduled deliveries.**



RPC Data Summary

September 2010 - November 2012

Scheduled delivery

- 8,719 Scheduled Deliveries
  - 61 percent C-sections
  - 39 percent Inductions

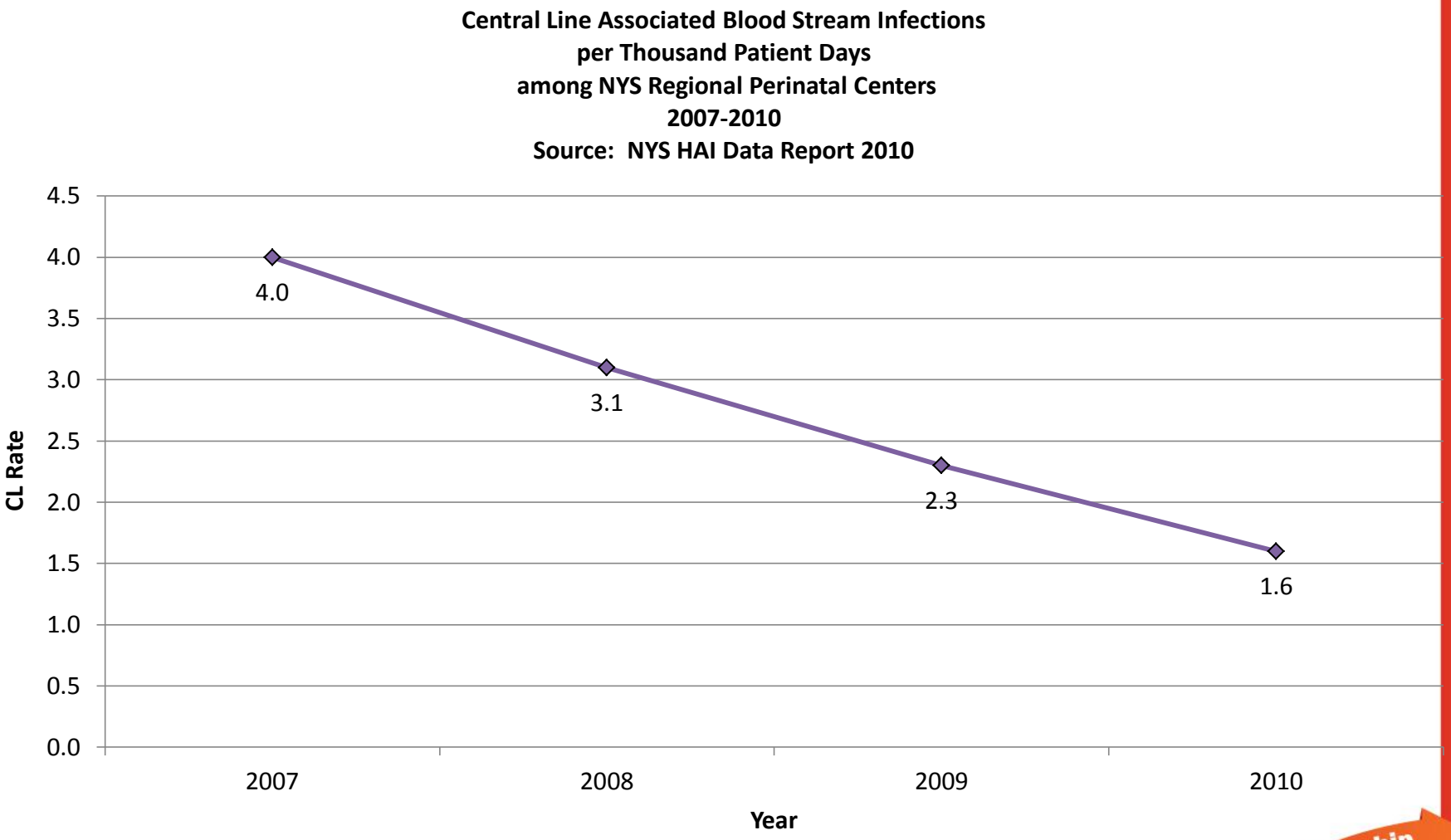
Scheduled deliveries without medical indication

- All scheduled deliveries ***decreased*** by 61.3 percent
- Induction ***decreased*** by 74.5 percent
- C-sections ***decreased*** by 57.7 percent

Maternal Education about preterm delivery increased by 60.9 percent

NICU CLABSI Reduction Project
RPC Results

Have we reduced CLABSI rates?



"Check, check, check, check, check" Gawande

Gawande: The Checklist. The New Yorker, Dec 10, 2007

Steps are no-brainers; known and taught for years

- Except, in more than a third of patients, doctors skipped at least one.
- New rule: if doctors didn't follow every step on the checklist, the nurses would have backup from the administration to intervene.
- Ten-day line-infection rate went from 11 percent - 0.
- In this one hospital, the checklist prevented 43 infections, 8 deaths, and saved $2 million.

(1) Wash hands with soap.

(2) Clean the patient's skin with chlorhexidine antiseptic.

(3) Put sterile drapes over the entire patient.

(4) Wear a sterile mask, hat, gown, and gloves.

(5) Put a sterile dressing over the catheter site once the line is in.

Pronovost 2001:

Line infection checklist

Journal of Perinatology (2009) 29, 591–599

www.nature.com/jp

SPECIAL FEATURE

Development of a statewide collaborative to decrease NICU central line-associated bloodstream infections

J Schulman[1,2,3], RL Stricof[4], TP Stevens[5], IR Holzman[6,7], EP Shields[8], RM Angert[9], RS Wasserman-Hoff[10], SM Nafday[9] and L Saiman[11], for the New York State Regional Perinatal Centers and the New York State Department of Health

[1]Department of Pediatrics/Newborn Medicine, Weill Cornell Medical College, Weill Cornell Medical Center, New York, NY, USA; [2]Deparment of Public Health/Outcomes and Effectiveness, Weill Cornell Medical College, Weill Cornell Medical Center, New York, NY, USA; [3]New York Presbyterian Hospital, Weill Cornell Medical Center, New York, NY, USA; [4]New York State Department of Health, Bureau of Healthcare-Associated Infections, Albany, NY, USA; [5]Division of Neonatology, Department of Pediatrics, University of Rochester School of Medicine, Rochester, NY, USA; [6]Department of Pediatrics, Mt. Sinai School of Medicine, New York, NY, USA; [7]Department of Obstetrics, Gynecology and Reproductive Science, Mt. Sinai School of Medicine, New York, NY, USA; [8]New York State Department of Health, Bureau of Women's Health, Albany, NY, USA; [9]Section of Neonatology, Department of Pediatrics, Albert Einstein College of Medicine, Bronx, NY, USA; [10]Division of Neonatology, Department of Pediatrics, New York University School of Medicine, New York, NY, USA and [11]Division of Infectious Diseases, Department of Pediatrics, Columbia University College of Physicians and Surgeons, New York, NY, USA

Reaching the Goal

December 2012

- Project participant, Albany Medical Center, announces their NICU has ***ZERO*** CLABSIs over a twelve month period!

Infection fight at Albany Med reaps rewards

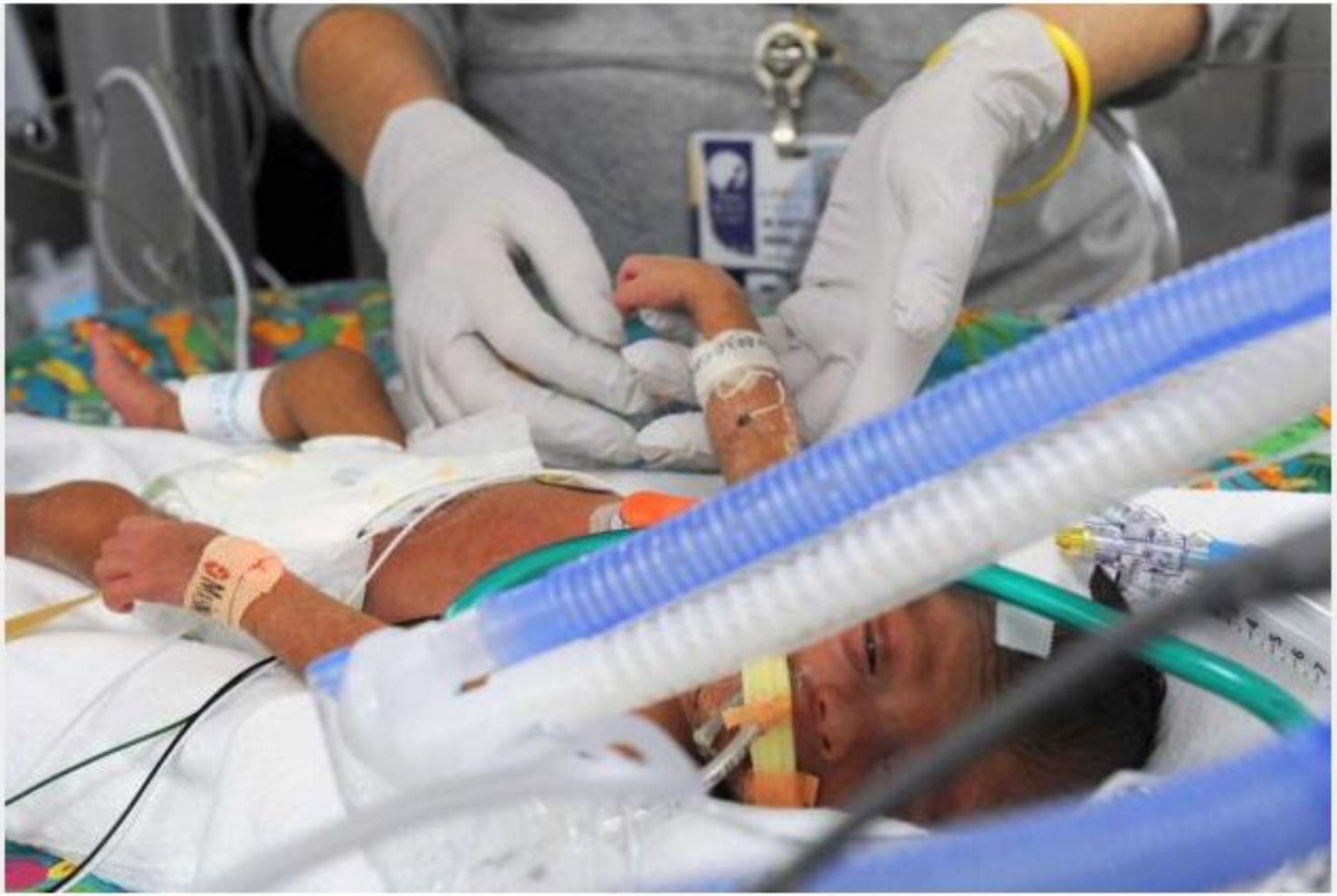
Neonatal intensive care unit marks a full year with no central line infections

By Cathleen F. Crowley

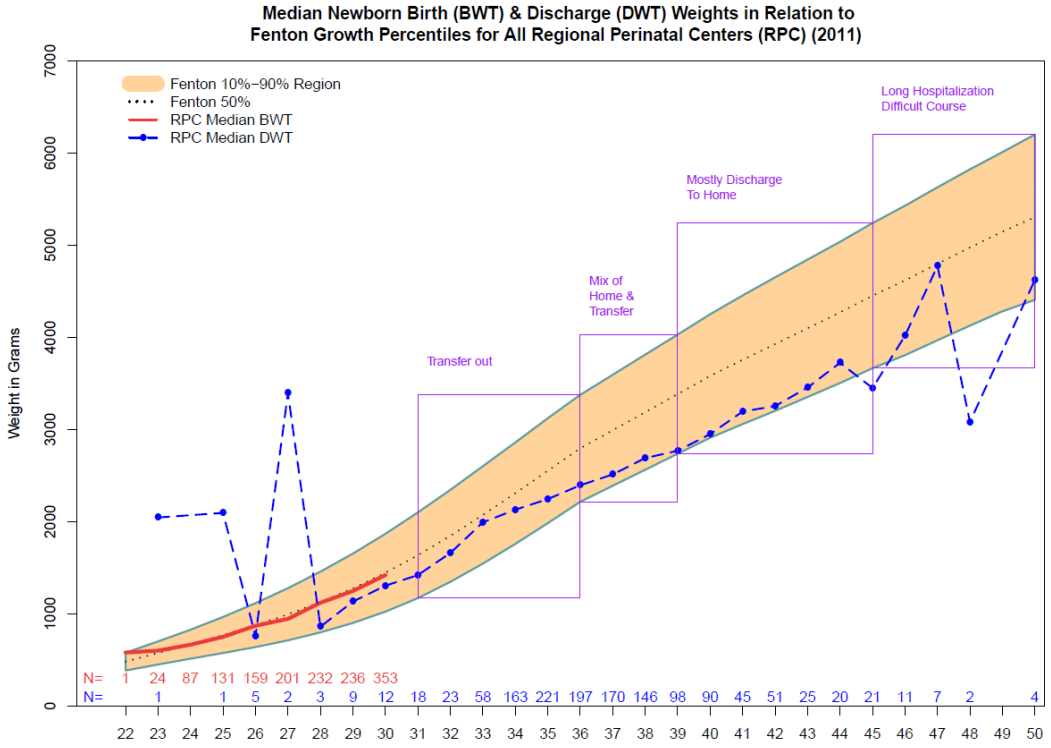
Published 7:39 pm, Wednesday, December 12, 2012

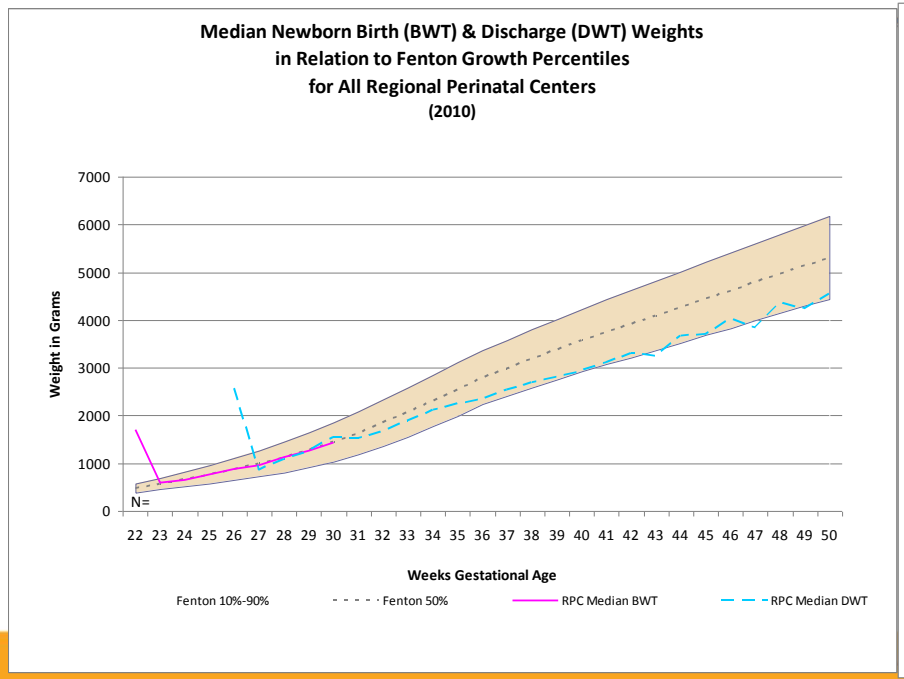
VIEW: LARGER | HIDE

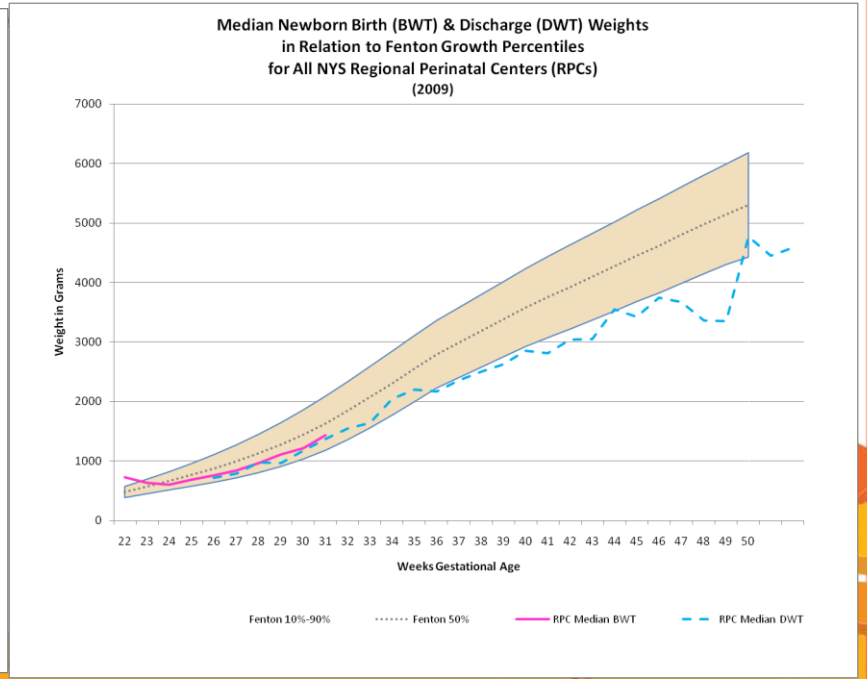
1 of 6 ◄ PREV NEXT ►

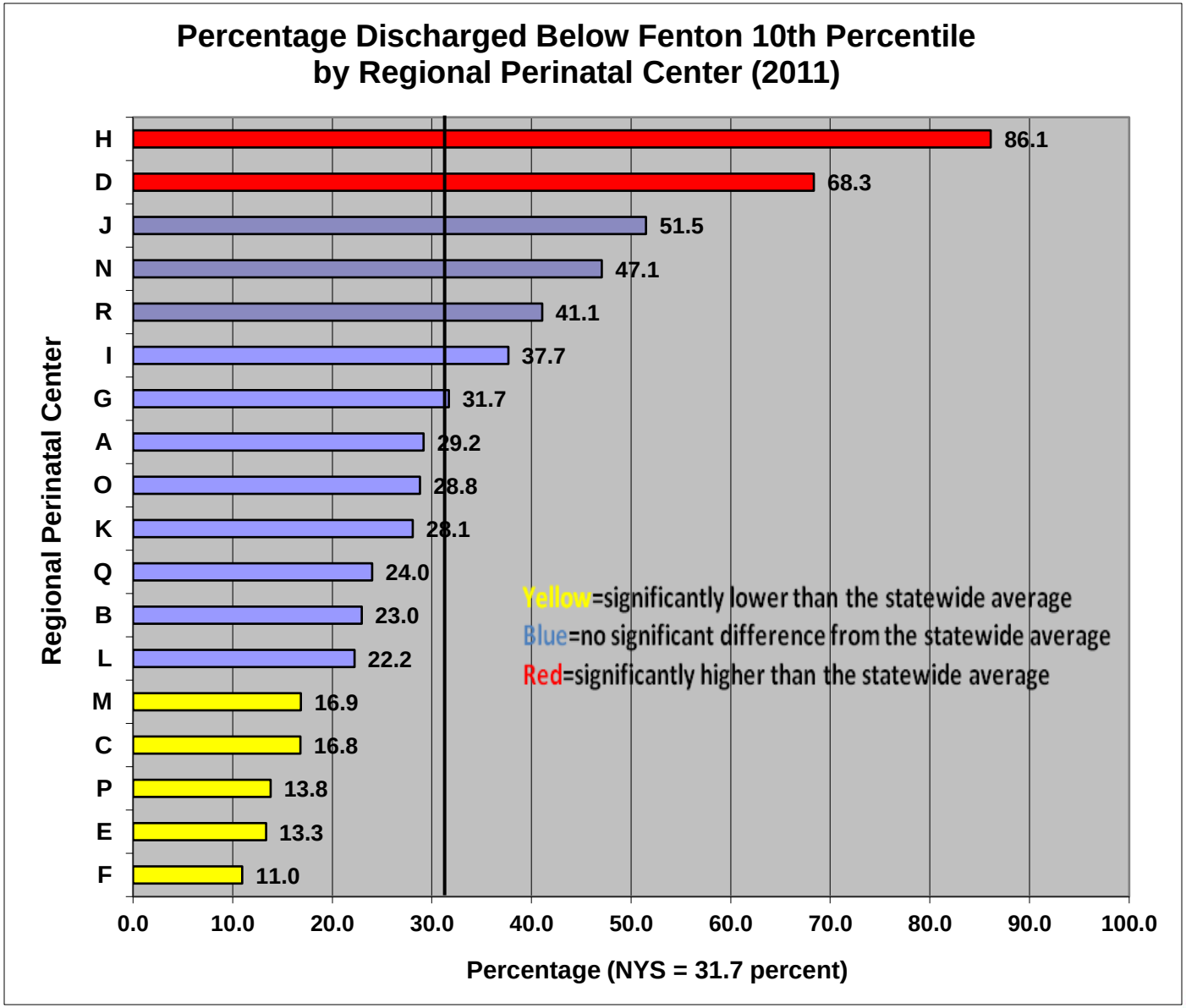


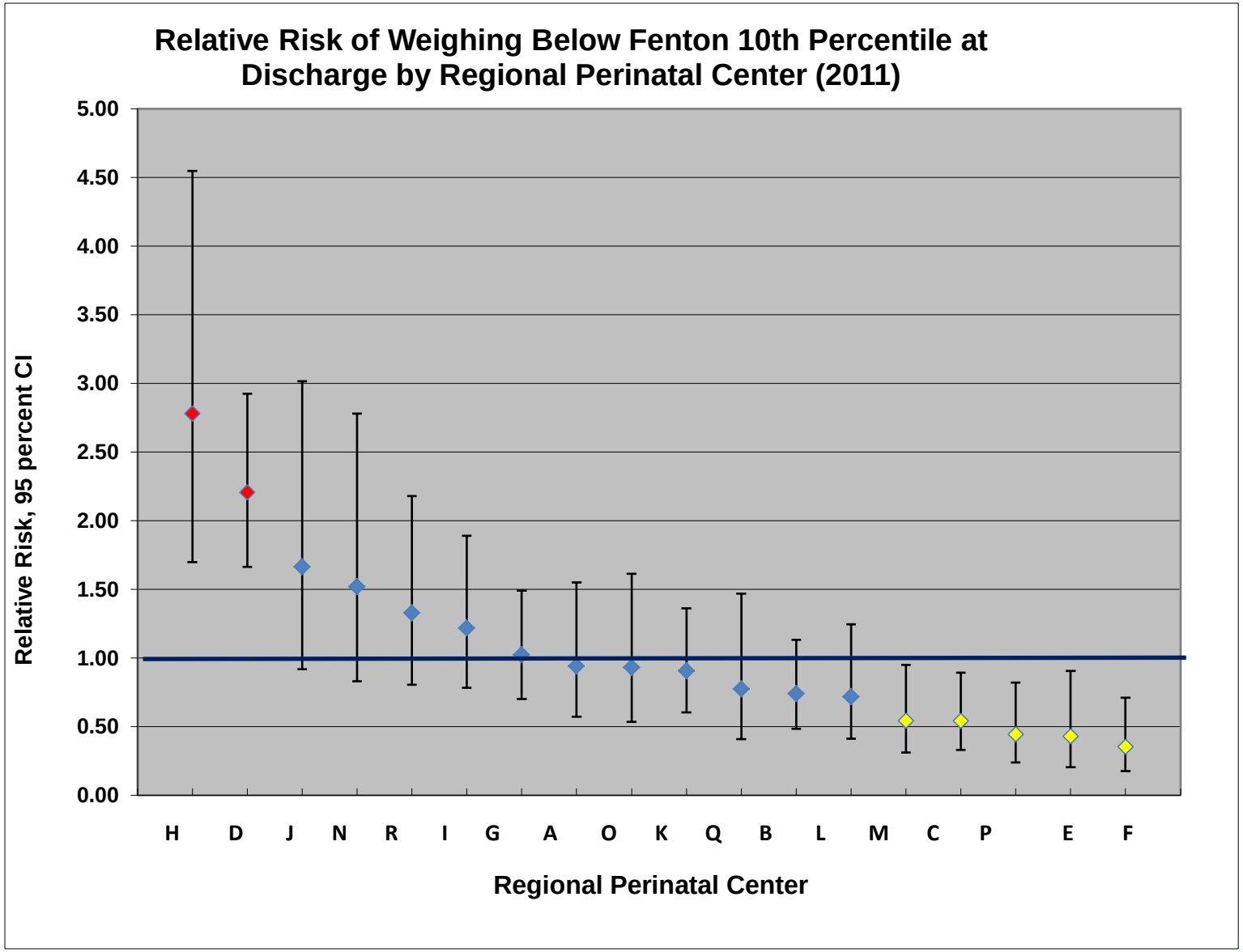
Enteral Feeding Improvement Project RPC Results


Median Newborn Birth (BWT) & Discharge (DWT) Weights in Relation to Fenton Growth Percentiles for All Regional Perinatal Centers (RPC) (2011)
Fenton 10%–90% Region
Fenton 50%
RPC Median BWT
RPC Median DWT
Long Hospitalization Difficult Course
Mostly Discharge To Home
Mix of Home & Transfer
Transfer out
Weight in Grams
N= 1 24 87 131 159 201 232 236 353
N= 1 1 5 2 3 9 12 18 23 58 163 221 197 170 146 98 90 45 51 25 20 21 11 7 2 4


Median Newborn Birth (BWT) & Discharge (DWT) Weights in Relation to Fenton Growth Percentiles for All Regional Perinatal Centers (2010)
Weight in Grams
N=
Weeks Gestational Age
Fenton 10%-90%
Fenton 50%
RPC Median BWT
RPC Median DWT


Median Newborn Birth (BWT) & Discharge (DWT) Weights in Relation to Fenton Growth Percentiles for All NYS Regional Perinatal Centers (RPCs) (2009)
Weight in Grams
Weeks Gestational Age
Fenton 10%-90%
Fenton 50%
RPC Median BWT
RPC Median DWT


Percentage Discharged Below Fenton 10th Percentile
by Regional Perinatal Center (2011)
Regional Perinatal Center
H
D
J
N
R
I
G
A
O
K
Q
B
L
M
C
P
E
F
86.1
68.3
51.5
47.1
41.1
37.7
31.7
29.2
28.8
28.1
24.0
23.0
22.2
16.9
16.8
13.8
13.3
11.0
Yellow=significantly lower than the statewide average
Blue=no significant difference from the statewide average
Red=significantly higher than the statewide average
0.0
10.0
20.0
30.0
40.0
50.0
60.0
70.0
80.0
90.0
100.0
Percentage (NYS = 31.7 percent)


Relative Risk of Weighing Below Fenton 10th Percentile at Discharge by Regional Perinatal Center (2011)
Relative Risk, 95 percent CI
5.00
4.50
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
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Regional Perinatal Center

Lessons Learned

- Limited resources can create big results
- Finding champions and "early adopters" is a key to success
- Facilities learn from each other
  - Higher performing teams served as teachers and mentors to others
- Facilities want to be a part of something if other facilities are engaged

Success Leads to Spread, Additional Partnerships and Collaborations

Increase in Funding

September 2011

- Perinatal Quality Collaborative grant from **Centers for Disease Control and Prevention (CDC)**
  - Three states received grant
    - California
    - Ohio
    - New York

Expansion of Collaborative

- Expanded existing obstetric and neonatal projects
- Added maternal mortality initiative to scope of Collaborative
- Were able to add:
  - Project Coordinator
  - Data Analyst

Obstetrical Improvement Project Expansion

Expansion of NYSPQC Obstetrical Improvement Project

- Based on success of RPC Collaborative, plan to expand project to all birthing hospitals in New York State
  - Align with New York State Partnership for Patients

Partnership for Patients

- Funded by the **Centers for Medicare and Medicaid Services (CMS)**

- Public-private partnership working to improve the quality, safety and affordability of health care for all Americans

NYS Partnership for Patients

- Joint initiative of the **Healthcare Association of New York State** and **Greater New York Hospital Association**
- Projects focus on:
  - Nursing centered initiatives
  - Infection prevention
  - Preventable readmissions
  - Building culture and leadership
  - Obstetrical safety

Partnership with NYSPFP

March 2012

- **<u>Common focus area:</u>**
  Reducing scheduled delivery without a medical indication between 36 0/7 and 38 6/7 weeks gestation
- NYSPQC's Obstetrical Improvement Project and NYSPFP's Obstetrical Safety Project unite as one initiative

Partnership with NYSPFP

- NYSPFP offers many resources to the NYSPQC Obstetrical Improvement Project:
  - Project managers
  - Onsite support
  - Educational opportunities
  - Obstetrics safety curriculum
  - Meeting resources

Expansion of NYSPQC Obstetrical Improvement Project

May 2012

- Recruitment of RPC affiliate birthing hospitals began
  - Recruitment Package
  - Informational Calls
  - In-person Learning Sessions
  - Recruitment supported by:
    - Regional Perinatal Centers
    - Project Managers

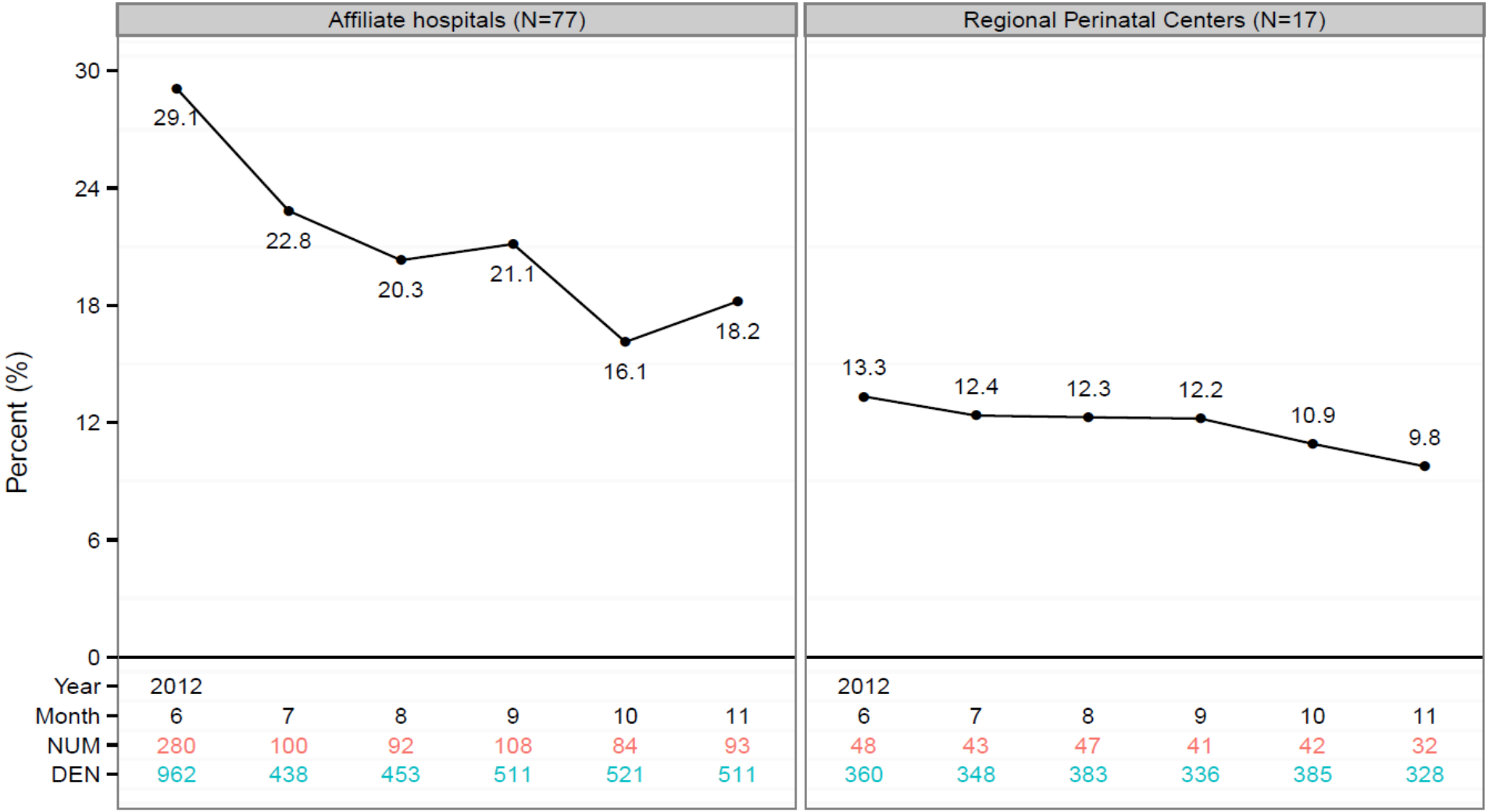
Expansion of NYSPQC Obstetrical Improvement Project

January 2013

- 100 facilities signed on to participate, of 130 New York State birthing facilities
  - 18 RPCs
  - 82 RPC affiliates

percent All Scheduled Deliveries Without Indication

Measure 3. Percent of **all scheduled deliveries** at 36 0/7 to 38 6/7 weeks without medical or obstetrical indication documented of all scheduled deliveries.



Scheduled Inductions with No Indication (Of All Scheduled Deliveries)

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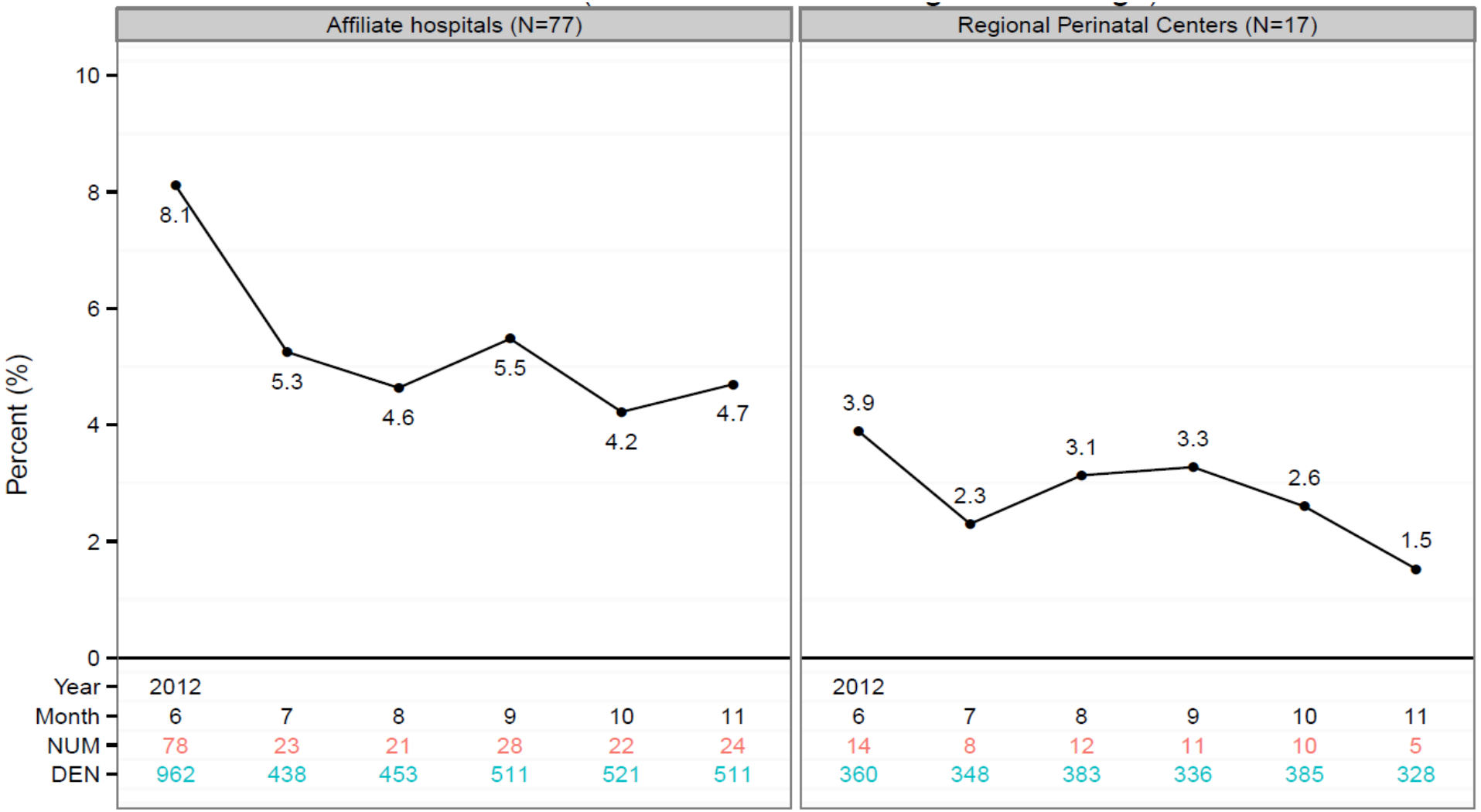
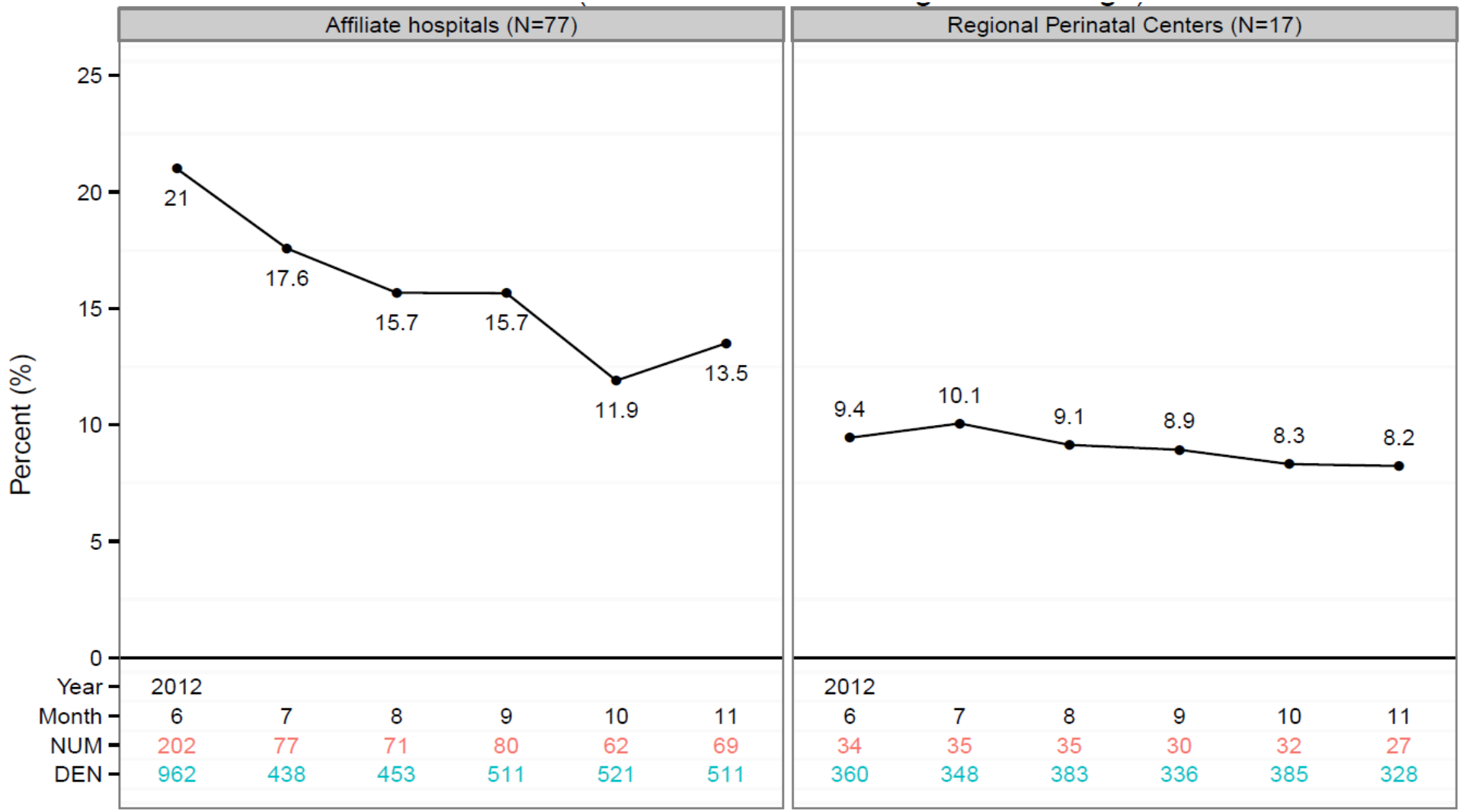


percent Scheduled C-sections with No Indication (Of All Scheduled Deliveries)

Measure 2a. Percent of **scheduled C-sections** at 36 0/7 to 38 6/7 weeks without medical or obstetrical indication documented of all **scheduled deliveries.**



Affiliate Data Summary

June 2012 - November 2012

Scheduled delivery

- 3,396 Scheduled Deliveries
  - 60 percent C-sections
  - 40 percent Inductions

Scheduled deliveries without medical indication

- All scheduled deliveries ***decreased*** by 37.5 percent
- Induction ***decreased*** by 42 percent
- C-sections ***decreased*** by 35.7 percent

Maternal Education about preterm delivery increased by 23.2 percent

NICU CLABSI Reduction Project Expansion

Expansion of NICU CLABSI Reduction Project

- Expand previous Collaborative work to RPCs and Level III nurseries
  - 18 RPCs and 35 Level IIIs
- Working with **New York State Department of Health Hospital Acquired Infections Program**

Maternal Mortality Review

Maternal Mortality Review

- Comprehensive statewide surveillance for pregnancy associated and related deaths
- Enhance the work of the existing Maternal Mortality Review initiative, and broaden the project over time
  - Maternal Mortality Advisory Committee
  - MMR Hypertension Subcommittee
    - Hypertension guidelines

Lessons Learned

- Buy-in from administration is important
  - Include administration in the process
  - Ask for administration signature on Participant Form
- Buy-in from physicians is important
  - Discover common purpose
  - Educate and inform leaders
  - Involve physicians from the beginning
  - Work with early adopters

Partnerships and Collaborations Continue to Grow

March of Dimes

- Works closely with NYSPQC Obstetrical Improvement Project
- Big 5 State Collaborative
- ASTHO President's Challenge

Medicaid Redesign Initiative

- **New York State Department of Health Office of Health Insurance Programs**
- Restructuring of Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and more efficient administrative structure
  - Financial incentives to reduce inappropriate use of scheduled delivery

CMS Adult Measures Grant

December 2012

- **New York State Department of Health Office of Quality and Patient Safety**
- Increase education of pregnant women about the maternal and fetal risks of scheduled delivery without a medical indication

Hospital-Medical Home Demonstration Project

December 2012

- **New York State Department of Health Office of Quality and Patient Safety**
- Improve coordination, continuity and quality of care
- Funds to hospitals expanding continuity training experience to residents

Hospital-Medical Home Demonstration Project

- Project requires each facility to implement one system improvement and two Quality and Safety Improvement Projects (QSIPs)
- Two of the six QSIPs are:
  - Avoidable preterm births to reduce elective delivery prior to 39 weeks
  - Neonatal outcomes
    - CLABSI reduction
    - Enteral feeding improvement

CDC/AMCHP Maternal Mortality Initiative

November 2012

- National Maternal Mortality Collaborative
  - **Goal:**
    Develop recommendations and standards to strengthen existing / guide new maternal death review processes
  - **Initiative Partners:**
    CDC, AMCHP, HRSA, ACOG
    14 States and 1 City

Lessons Learned

- Important to get the message out about what's taking place
  - Potential partners and collaborators more likely to consult with you

- Once the message is out, it becomes easier to leverage funding opportunities

Final Thoughts

- Communication is key
  - Regularly speak directly with Collaborative participants for feedback
  - Create an open dialogue
- Everyone has something to contribute
  - Those who are advanced, in the middle, or just beginning
  - We can all accomplish more when we work together!

Final Thoughts

- Collaboration improves outcomes
- When we collaborate, we bring more power to an issue
- There is always room for improvement

NYSPQC Project Team

- Marilyn Kacica, MD, MPH
- Chris Kus, MD, MPH
- Kristen Farina
- Todd Gerber
- Eileen Shields
- Harry Xiong
- Colleen Signer

Questions?

Contact

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Enhancing Racial and Ethnic Health Care Equity Through Group Prenatal Care

Elizabeth Riggs, MPH
March of Dimes Chapter Programs

Sharon Schindler Rising, MSN, CNM, FACNM
Centering Healthcare Institute, Inc.

Julie Solomon, PhD
J. Solomon Consulting, LLC

Workshop Objectives

- Describe strategies to improve recruitment and retention of African-American women in CenteringPregnancy (CP)

- Identify program elements essential to successful systems change and CP model sustainability

Study Description

Study Partners:	**March of Dimes Foundation**
	Centering Healthcare Institute (CHI)
	J. Solomon Consulting, LLC
Co-Investigators:	**Scott D. Berns MD, MPH, FAAP**
	Diane M. Ashton MD, MPH, FACOG
Study Period:	**March 2011-June 2013**

This study is supported by The Aetna Foundation.

75 years

march of dimes

Study Goals and Components

Study Purpose: Reduce Disparities in Preterm Birth

Study Goals:

- **Increase effectiveness of CenteringPregnancy program implementation**
- **Enhance patient participation and satisfaction with care, particularly for African-American women**

Study Components:

- **Site Approval Visits to assess program implementation**
- **Focus groups with staff and African-American patients to identify barriers to program implementation and participation**
- **Process and outcome data collection to measure program reach and birth outcomes**

Study Sites

Access Community Health Network (Chicago, IL)

All Women's Health (Savannah, GA)

Baptist Health Care (Montgomery, AL)

Cabarrus Health Alliance (Kannapolis, NC)

JFK Medical Center (Edison, NJ)

Legacy Midwifery (Portland, OR)

VNA Health Care (Aurora, IL)

Washington Hospital Center (Washington, D.C.)

The *Centering* Group Care Model

Health Assessment

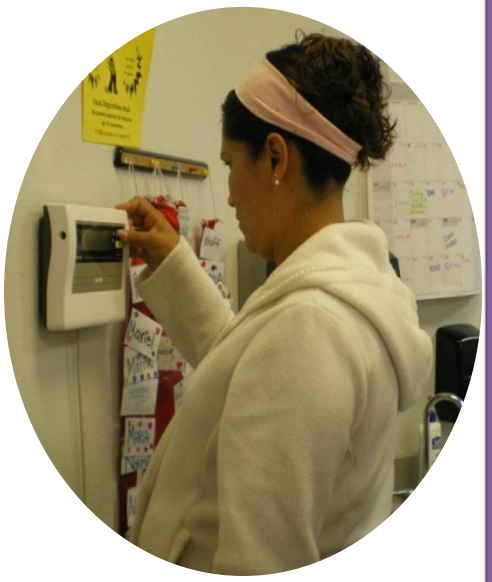
Education

Support

Three Components of Care

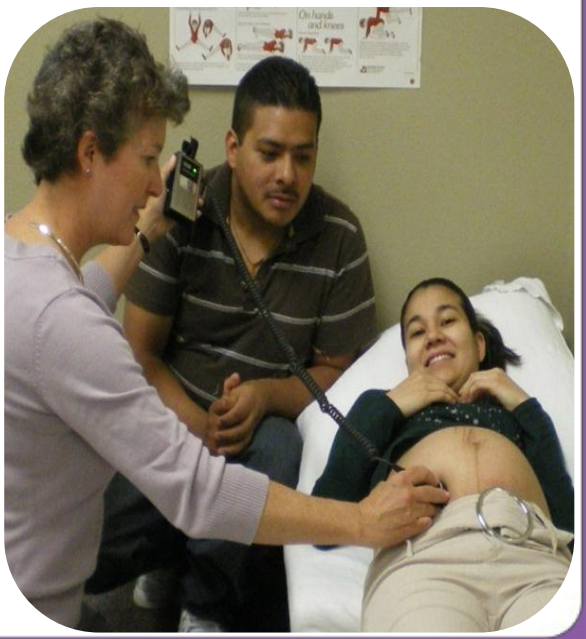
Health Assessment

Individual health assessment with provider in group space



Women collect and record own health data

10 sessions throughout pregnancy/early postpartum



Education

Time to talk in depth about issues of importance

Session plan and self-assessment sheets guide discussion

Exploration of cultural beliefs and values enhances content

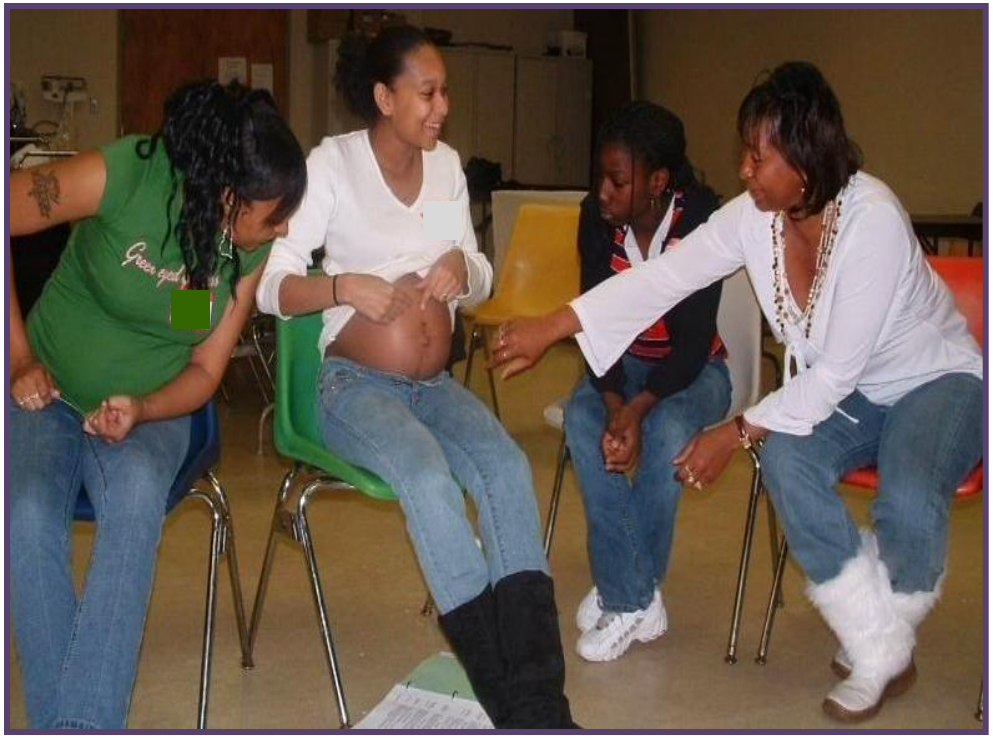
Efficient way to share information

Process driven rather than didactic presentation

Education: Discussion Topics

Communication Sexuality/contraception

Birth preparation



Nutrition & infant feeding

Comfort measures Stress management

Support

Stability of group provides opportunity for creating a network of friends

Fun, interactive sharing helps unite the group in moving toward common goals

Centering Care

- **Meets or beats productivity**
  - 10 -12 patients for 1.5-2 hour visit
  - Better attendance
  - Opens exam rooms for other paying visits
- **Reimbursed healthcare visits**
  - Same or higher reimbursement
- **No waiting times**
  - Access to care
  - Efficient for patients and providers
- **Continuity of care with same provider**
- **Engaging and fun**

What Are the Outcomes?

- Higher patient satisfaction
- Better prenatal care attendance
- 33 percent decrease in preterm birth rate
- Increased breastfeeding rates (Ickovics et al., 2007)

- Decreased sexually transmitted diseases
- Longer interconceptional period (Kershaw et al., 2009)

- Decreased postpartum BMI
- Increased immunization rates (As yet unpublished)

References

Ickovics JR, Kershaw TS, Westdahl C, Magriples U, Massey Z, Reynolds H, and Rising SS (2007). Group prenatal care and perinatal outcomes: a randomized controlled trial. *Obstetrics & Gynecology*, *110*(2 Pt 1): 330-339.

Kershaw TS, Magriples U, Westdahl C, Rising SS, and Ickovics J (2009). Pregnancy as a window of opportunity for HIV prevention: effects of an HIV intervention delivered within prenatal care. *American Journal of Public Health*, *99*(11): 2079-2086.

Focus Groups: Methods

- Four focus groups with CP patients
  - African-American women, in 3rd trimester of pregnancy
  - Conducted in-person by CHI site approval consultant
- Four focus groups with CP staff
  - All professions (nurses/NPs, physicians, medical assistants, etc.)
  - Conducted via phone by research staff
- Analysis
  - Cross-site and cross-population (patient/staff) assessment
  - Thematic focus: recruitment, engagement, satisfaction, retention, implementation, sustainability, and outcomes

Focus Group Participants*

CP PATIENTS N = 22 African-American women, 4 sites		
Age	18-29	91 percent
	30-40	9 percent
Education**	< H.S.	10 percent
	H.S. grad/GED	43 percent
	> H.S.	48 percent
Gravida	1st pregnancy	45 percent
In CP in previous pregnancy	Yes	9 percent

CP STAFF N = 21 staff, 4 sites		
Race/ethnicity	African-American	43 percent
	White	43 percent
	Hispanic	10 percent
	Other	5 percent
Profession	Nurse/NP/ Nurse Midwife	38 percent
	Physician	19 percent
	Medical Asst.	19 percent

Cross-Site/Cross-Population Findings: Appealing Attributes

- No wait time for prenatal care appointment
- Opportunity to learn about healthy pregnancy, birth, and newborn care
- Opportunity to share and bond with other similar women and with CP facilitators
- Availability of snacks and other incentives during sessions
- Self-monitoring/self-recording of weight and blood pressure
- "It's fun"

"They [pregnant women] hear it from the other mothers how wonderful the program is, that we feed them, we do not make them wait for appointments, they have fun, they get to intermingle and meet other people that have common interests." (CP staff)

"I thought it would be nice to be around other pregnant women to see what they're going through...." (CP patient)

Cross-Site/Cross-Population Findings: Program Benefits

- Key benefits for patients
  - Increased interest in a healthy pregnancy
  - Improved nutrition and exercise
    - High rates of obesity and diabetes among patients
  - Increased sense of support and reduced stress
    - Break from stress at home/work
    - Opportunity to share and get support from other pregnant women
    - Information about what to expect in labor and delivery
    - Support from facility staff and referrals to other services

"We talk about our stress. They let us talk about what we're going through and they help me feel better." (CP patient)

"The peers themselves provide a lot of support and emotional succor… [that] seem to empower the patient to be able to cope a little bit better."
(CP staff)

Cross-Site/Cross-Population Findings: Challenges

- Recruitment, Retention, and Engagement
  - Reluctance to enroll in CP
    - Lack of familiarity with CP/not knowing what to expect
    - Discomfort sharing personal information in a group setting
    - Concern with not having one-on-one relationship with provider
  - Transportation difficulties
  - Room set-up: Physical size, configuration, exams on the floor, patient privacy

"At first I was kind of skeptical about [joining CP], because... I didn't really want to talk my business in front of everybody. But then once we got in the group I got comfortable with it." (CP patient)

Cross-Site/Cross-Population Findings: Ways to Strengthen CP

- Recruitment/Enrollment
  - Give all patients opportunity to try CP
  - Emphasize no wait to see provider and group support
  - Involve other CP patients or staff in recruitment

- Retention and Engagement
  - Offer transportation supports and other incentives
  - Optimize CP space
  - Emphasize confidentiality of information shared
  - Maximize social supports and discussion of topics raised by patients

"...[T]he challenge is getting patients in... because they didn't understand what it was..... but whenever they came in, they liked it...." (CP Staff)

"One thing that will attract black women is seeing another black woman reaching out." (CP patient)

13
Essential Elements

Define the Centering Model

Group Space

Centering requires a private, adequately sized, appropriately decorated, dedicated Centering space.

Physical assessments occur within the group.

The group is conducted in a circle.

It should feel like a "nest."

Facilitative Leadership

"I think on occasion, [some women] feel a little intimidated in the healthcare setting and not … as free to open up. And then in the group setting, there are other young African-American women - some of that social structure falls away. They're just a little bit more willing to talk about things. I think that group environment really does go a long way to eliminating that distance that sometimes can exist between a patient and healthcare provider."

(CP Staff)

Women Involved in Self Care

"I'd be monitoring more that I'm doing it myself versus the doctor taking my weight and writing it down." (CP patient)

"It makes you feel more drawn to your pregnancy so I like it." (CP patient)

"It's kind of training us to be able to do stuff for ourselves." (CP patient)

Group Size Is Optimal

In order to achieve groups of 8-12 women with good retention rates, it is helpful if sites:

- Actively work toward CP as the standard of care.
- Have senior leadership that is committed to "making sure it works" rather than "seeing if it will work."
- Have more than two provider teams.

With optimal group size, providers meet productivity goals, the model is cost-effective, and, with multiple provider teams, the model is more sustainable.

Evaluation of Outcomes

Benchmarks included:

- Attendance
- Gestational age
- Birthweight
- C-section rate
- Appropriate weight gain
- Breastfeeding
- Postpartum depression screen
- Contraceptive use

Process evaluation form used to evaluate group experience and plan for future groups

MAKING IT WORK: STEERING COMMITTEE

Team building

Guides the process of change

to implement and maintain

Centering

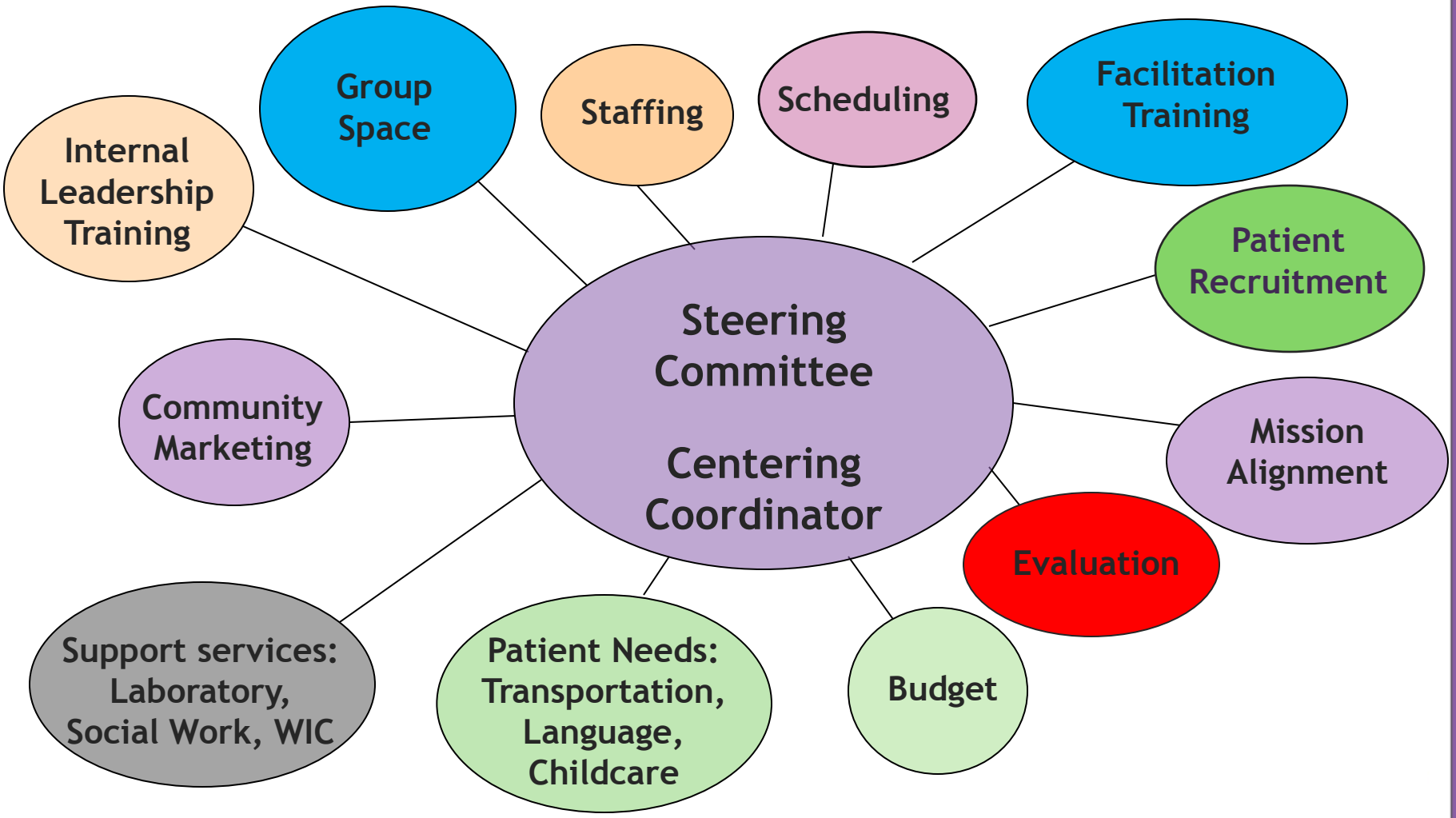
Administrators, clinicians, agency staff, patients/families

"Our active Steering Committee is making all the difference to the success of our new CenteringPregnancy model"

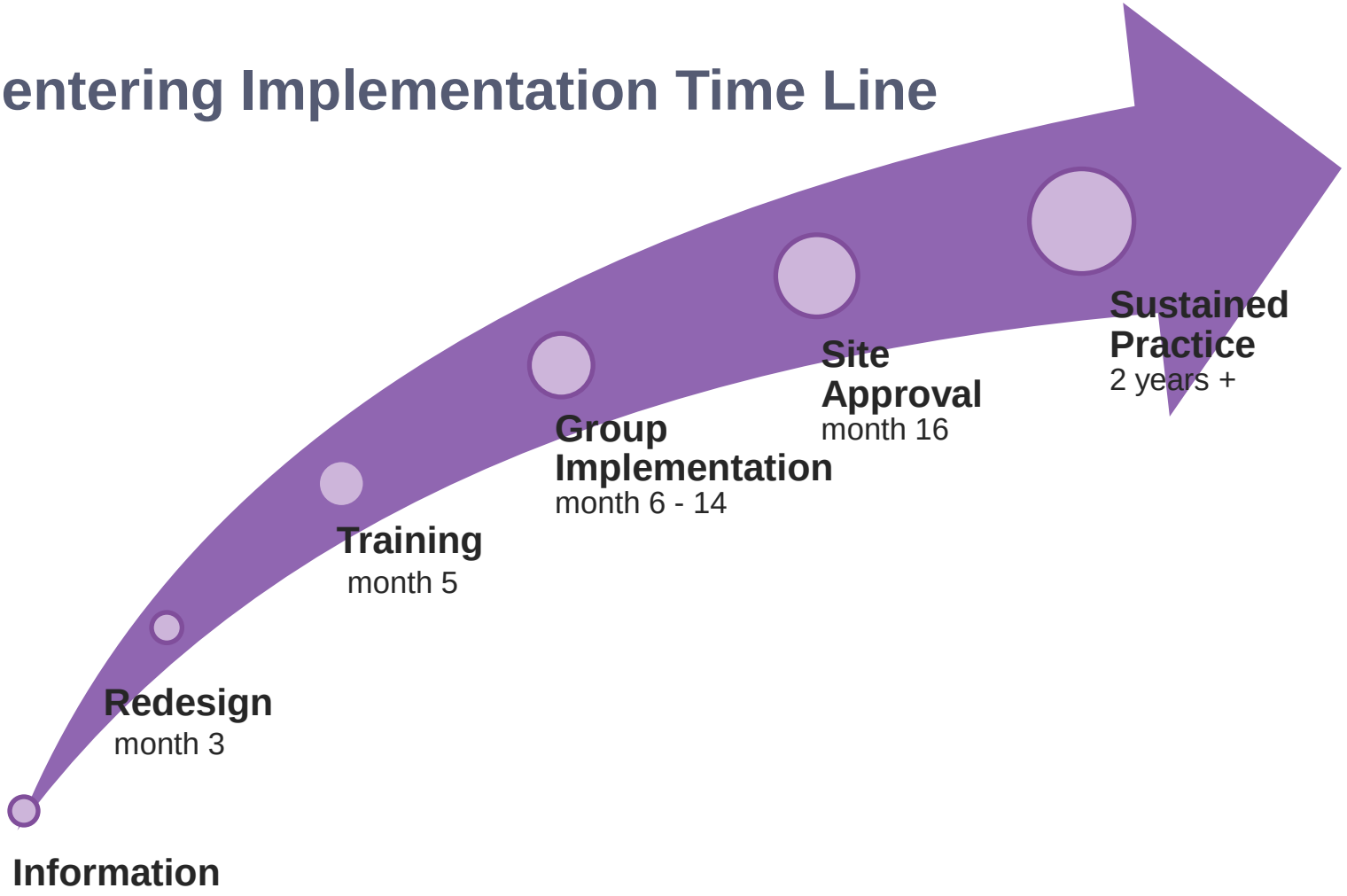
75 years

march of dimes

SYSTEM REDESIGN COMPONENTS



Centering Implementation Time Line



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